Information from the
Missouri Department of Elementary and Secondary Education
HIV Prevention Education Program - 573-751-3805
http://www.dese.state.mo.us/divimprove/curriculum/hiveducation/index.htm

Frequently Asked Questions about HIV/AIDS Prevention Education in Schools

Is HIV/AIDS prevention education required to be taught in Missouri schools?

Yes. The Missouri School Improvement Program (MSIP) adopted by the Missouri State Board of Education in 1993, and revised in 1997, requires that schools provide comprehensive health instruction, including tobacco, alcohol, and other drug prevention and HIV/AIDS prevention education, as follows:

a) Each elementary student must receive regular instruction.
b) Each junior high/middle school student must receive a minimum of 1,500 minutes of instruction each year.
c) Each high school must offer a minimum of 0.5 unit of credit for graduation.

Does this mean AIDS education must be provided for primary-age elementary students?

Yes. However, HIV/AIDS prevention education taught within the context of comprehensive health instruction will include developmentally-appropriate messages and skill development for learning how to take care of the body. For example, AIDS prevention for primary-age students may focus on acquiring good personal habits that prevent the spread of disease.

Are there requirements for the content of AIDS education and the amount of instruction?

No. Local school districts determine the amount and content of HIV/AIDS prevention education provided. Guidance is provided in *Missouri's Framework for Curriculum Development in Health Education and Physical Education (Healthy, Active Living) K-12*.

Would an assembly meet the requirement?

Yes. However, evidence from effective HIV/AIDS prevention education suggests that an assembly by itself will not reduce risk behaviors of students.

What evidence exists that school-based HIV/AIDS prevention education works?

A review by the Centers for Disease Control and Prevention of 23 school-based programs found that some, but not all, were effective in reducing sexual risk behaviors among school-age youth. Effective programs produced one or more of the following: 1) delayed initiation of sexual intercourse, 2) reduced frequency of intercourse, 3) reduced number of sexual partners, or 4) increased use of condoms or other contraceptives. **No programs produced an increase in sexual activity among students.**

Programs that were effective shared the following characteristics:

1) Curricula were based on social learning or social influence theories.
2) Each focused on reducing specific sexual risk-taking behaviors that may lead to HIV infection, other STDs, or unintended pregnancy.
3) Basic, accurate information about the risks of unprotected sex and how to avoid the risks were presented using experiential activities which personalized the information for students.
4) Instruction included activities for handling social or media influences and pressures on sexual behaviors.
5) Individual values and group norms against unprotected sex were reinforced in developmentally-appropriate ways.
6) Communication and negotiation skills were modeled and practiced and efforts were made to increase student confidence to use the skills.

Programs that were ineffective covered a broader array of topics and were less focused on specific risk behaviors for HIV/STD infection and unintended pregnancy. Ineffective programs did not help students apply information and skills to a clear set of values and norms for avoiding unwanted or unprotected sexual intercourse.

Source: "School-Based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*. May-June 1994, Vol. 109, No. 3, pp. 339-359.